

Table 1 BV prevalence results

Lesbians	No of women	BV diagnosed
Total	17	6 (35%)
Practised receptive cunnilingus in previous 4 weeks	9	6 (67%)
Did not practise receptive cunnilingus	8	0
Heterosexual women	No of women	BV diagnosed
Total	256	55 (21%)
Practised receptive cunnilingus in previous 4 weeks	111	41 (37%)
Did not practise receptive cunnilingus in past 4 weeks	145	14 (10%)

endogenous healthy vaginal lactobacillus? In an interesting hypothesis, Blackwell described the possible effect of biochemical and microbial abnormalities in the vagina on BV recurrence.³ She also quoted Berger's description of concordant vaginal floras in lesbian couples, suggestive of a mechanical transfer of an infectious agent.³ Is it not possible for mouth organisms or hostile salivary enzymes to induce biological and microbial abnormalities in the vagina?

Furthermore, mechanical transfer of infectious agents in lesbian couples is most likely to occur via cunnilingus, a not uncommon practice among lesbians.

Cunnilingus is a common fact of sexual life. The dynamics of this practice vary considerably. If association between BV and oral sex is ever confirmed, would the degree of tongue penetration be a factor and should it be incorporated in the aetiology equation? Further and more extensive studies are certainly indicated.

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Is partner notification in the public interest?

EDITOR,—This ethical debate¹ calls for comment.

Why did the clinicians only suspect AIDS? Surely at the second attendance the diagnosis was clinically obvious. As well as continuing treatment of candidiasis and starting prophylaxis of *Pneumocystis carinii* pneumonia, was not treatment for AIDS indicated? For fear of court proceedings a specimen of blood untested or surplus to routine haematological tests could have been stored to confirm, if necessary, the clinical diagnosis. A perspicacious defence lawyer could make much of this in terms of doctor thoroughness, cautiousness, and thoughtfulness—on behalf of his client.

In terms of contact tracing the word "disclosure" occurs repeatedly. Surely the first thing an index case is told when his/her cooperation is sought is that under no circumstances will their name be divulged. The contacts, when attending, will be refused any information regarding who has named them and immediately assured that the same confidentiality will be maintained if their cooperation is called for in the contact tracing process.

Only when it becomes widely known in a clinic that such confidentiality is thoroughly pursued will counterproductive fears be eliminated. With understanding and cooperation it can be done.

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Sexual partner reduction and HIV infection

EDITOR,—We recently conducted a national urban random sample survey of 1400 men of sexually active age in the Dominican Republic to measure possible change in sexual behaviour. This sexual behaviour change (SBC) survey was prompted by results from the 1996 demographic and health survey, which found that 84.8% of a national random sample of Dominican men claimed that they had changed their behaviour in some way because of their fear of, or concern about, AIDS. The proportion of respondents reporting behaviour change such as becoming monogamous or reducing their number of sexual partners was about triple the proportion reporting condom adoption. In our SBC survey, 79% of respondents claimed to have changed behaviour because of concern about AIDS. A majority (52.2%) said they had become monogamous or reduced their number of sexual partners. This was followed by condom adoption (14.6%), only having sexual relations with a person they know (13.9%); avoiding relations with "prostitutes" (9.0%); or becoming abstinent (1.6%). A small proportion (2.8%) had not yet begun to have sexual relations. As with the Dominican DHS findings, we see that most answers are classifiable as behaviour change, as distinct from condom adoption. This follows a pattern found in recent studies in countries such as Uganda and Zambia. A recent review of findings from behavioural change surveys in 16 countries in Africa, Latin America, and the Caribbean shows that partner reduction is more often reported than condom adoption.¹ If sizeable numbers of men reduce their number of sexual partners, can this have significant impact on HIV infection rates? Urban HIV seroprevalence among the general or low risk Dominican population seems to have stabilised at the 1.9–2.0% level since 1995, according to the US Census Bureau. Recent studies that have modelled the impact of different interventions on HIV infection rates in east Africa suggest that reduction in number of partners can have a great impact on averting HIV infections, in fact greater than either condom use or treatment of STDs.^{2,3} Of course, impact of partner reduction on HIV infection rates would be espe-

cially strong where there is relatively high HIV seroprevalence among potential partners. In view of these modelling studies as well as population based surveys such as the two cited from the Dominican Republic, perhaps there ought to be greater equity in resource allocation between HIV/AIDS prevention programmes promoting behaviour change—such as monogamy/fidelity or at least reduction of number and frequency of change of sex partners—and far more familiar programmes that promote and provide condoms.

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Features of AIDS and AIDS defining diseases during the highly active antiretroviral therapy (HAART) era, compared with the pre-HAART period: a case-control study

EDITOR,—To assess the features of AIDS defining illnesses during the HAART era versus those observed before the introduction of HAART, the characteristics of 72 consecutive patients, diagnosed in 1997–9, were compared with those of 144 subjects randomly selected from the 436 patients diagnosed from 1985 to 1995, in a case-control study.

An impressive drop in AIDS diagnosis was seen shortly after the introduction of HAART, with only 38, 21, and 13 cases per ~1000 patient years observed in 1997, 1998, and 1999 respectively, versus a mean frequency >60 cases per ~1000 patient years, demonstrated during 1991–5. A tendency towards an increased incidence of female sex was shown in 1997–9 compared with 1985–95 (33.3% versus 27.1%), together with a rise of mean CD4+ lymphocyte count (86.8 (SD 99.4) versus 72.1 (93.7) cells ×10⁶/l), while an increase in the mean patient age was highly significant (39.8 (8.3) versus 34.6 (7.7) years; *p*<0.0001). When considering the exposure to HIV infection, drug abuse became significantly less important in the HAART era (*p*<0.05), while heterosexual transmission was notably increased (34.7% versus 13.2% of cases; *p*<0.0003). The distribution of AIDS defining disorders during the HAART era showed a tendency to a reduction in cytomegalovirus, cryptococcosis, mycobacteriosis, cryptosporidiosis, and HIV encephalopathy, while a relative increase in pneumocystosis, oesophageal candidiasis, wasting syndrome, tuberculosis, and non-Hodgkin's lymphoma was found; neurotoxoplasmosis and Kaposi's sarcoma were stable (table 1). However, while pneumocystosis, *Candida* oesophagitis, neurotoxoplasmosis, and Kaposi's sarcoma represented the four most frequent AIDS related events in both study periods, cytomegalovirus, HIV encephalopathy, cryptococcosis, and mycobacteriosis (which ranked fifth to eighth in